HICKSVILLE PUBLIC SCHOOLS
Office of the Registrar
Administration Building
200 Division Ave.
Hicksville, NY 11801
(516) 733-2160

NEW ENTRANT APPLICATION PROCESS

Required Forms for Registration:

- New Entrant Application
- Screening Program Form
- Health History Form
- Immunization Form
- Prior Special Education Services Form
- Home Language Form
- Census Form
- Affidavit
- Transfer of records
- Health Appraisal Form

Instructions:

1. Print legibly to complete all forms.
2. Collect the required documentation. Required documentation is listed on the following page.
3. Call the Registrar for an appointment at 733-2168.
4. Packet will be reviewed by Registrar.

HICKSVILLE PUBLIC SCHOOLS
Office of the Registrar

NEW ENTRANT REGISTRATION REQUIRED DOCUMENTATION

Parental Photo ID ___

Proof of Birth (1 Original Form)
___Original Birth Certificate or ___ Baptismal Certificate or ___ Passport

Proofs of Parental Relationship:
___ Birth Certificate ___ Baptismal Certificate ___ Court Guardianship Papers ___ Court Custody Papers ___ Divorce Decree ___ Adoption Papers
___ Affidavits of Residential Custodial and Non-Resident Custodial Parents
___ Affidavits of Emancipation

Immunization:
Four doses or three with one given after age 4 years of Polio (OPV and/or IPV)
Five DPT/DTap or four with one given after age 4 years or three doses if started after age 7 years
Two MMR or Two Measles, Two Mumps, Two Rubella-Measles first vaccine must be after one year of age
One Varicella in grades 2-5; 8-12; Two Varicella in grades K, 1, 6, 7
Three Hepatitis B—older students may have two doses adult vaccine (Recombivax)
One Pertussis (Tdap)—for older students entering Grade 6 in 2007 and for future students born on or after 1/1/94

Proof of Prior Schooling:
___Transfer Card/Request ___ Report Card(s) ___ Special Education Records (as appropriate)

HOMEOWNER	NON-HOMEOWNER/RENTER	FAMILY LIVING WITH ANOTHER FAMILY
THREE (3) original proofs as indicated below: **TWO** (2) ORIGINAL PROOFS FROM BELOW: House Title or Deed House Contract Real Estate Closing Statement Notarized Affidavit from the Homeowner Recent Nassau County Tax Bill Receipt from Homeowner Recent Mortgage Statement or Home Insurance Bill from Homeowner In addition, **ONE (1)** of the following **RECENT** original proofs in the Homeowner's Name from below: Recent Electric Bill Recent Water Bill Recent Cell Phone Bill Recent Oil Bill Recent Telephone Bill Recent Gas Bill Recent Cable/Satellite Bill Recent Security System Bill Recent Credit Card Bill	**THREE** (3) original proofs as indicated below: Notarized Affidavit from the Homeowner or Lease Recent Nassau County Tax Bill Receipt from Homeowner Recent Mortgage Statement from Homeowner Home Insurance Bill from Homeowner In addition to the above, **THREE (3)** of the following original proofs in the Renter's Name: Recent Bank Statement Recent Electric Bill Recent Cell Phone Bill Recent Oil Bill Recent Telephone Bill Recent Gas Bill Recent Cable/Satellite Bill Recent Security System Bill Recent Credit Card Bill	**THREE** (3) original proofs as indicated below: Notarized Affidavit from the Homeowner or Lease Recent Nassau County Tax Bill Receipt from Homeowner Recent Mortgage Statement from Homeowner Home Insurance Bill from Homeowner In addition to the above, **THREE (3)** of the following original proofs in the name of the Family living with the homeowner: Recent Bank Statement Recent Electric Bill Recent Cell Phone Bill Recent Oil Bill Recent Telephone Bill Recent Gas Bill Recent Cable/Satellite Bill Recent Security System Bill Recent Credit Card Bill

REVISED 6/22/15 FOR 2015-2016 SCHOOL YEAR

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, **the student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____ *Month Day Year* Grade: _____ *(preschool-12)* ID#: _____ *(optional)*

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Please check **one** box.*)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____

- ☐ In permanent housing

_____ _____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth) **Signature** of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Date

If the student is **NOT** living in permanent housing, **proof of residency** and other documents normally needed for enrollment are **not required** and the **student is to be immediately enrolled. After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

HICKSVILLE PUBLIC SCHOOLS
NEW ENTRANT APPLICATION
(please print)

Name of Pupil _____ Sex __M __F Date of Birth____/____/____
Last Name First Name M.I.

Address _____ Telephone No. _____
No. Street Town/State Zip Code

Homeless? ___ YES ___ NO Cell No. _____

Place of Birth _____ Date of Entry to US_____ Foster Child: _____ YES _____ NO
Town/State/Country

Date of first entry into a U.S. School: _____

PREVIOUS ADDRESSES (LAST 3 YEARS)	DATES FROM / TO	SCHOOL DISTRICT

Last School Attended _____ Grade Completed _____

School Address _____ Retained in Grade(s) _____

Has child attended school in Hicksville before? ____Y ____N If yes, School _____

Father's Name _____ Address _____
(If different than student(s)

Employed by _____ Business Telephone _____ Cell Phone _____ Occupation _____

Mother's Name _____ Address _____
(If different than student(s)

Employed by _____ Business Telephone _____ Cell Phone _____ Occupation _____

Family Physician _____
name address telephone no.

Emergency Contact _____
(Other than parent) name address telephone no.
Relationship_____

Ethnicity:
American Indian or Alaskan Native _____ Asian or Pacific Islander _____ Multiracial _____

Black _____ Primary Language: _____

White _____ Language(s) spoken in Home _____

Hispanic _____ Corresponding Language: _____

LIST NAMES OF OTHER CHILDREN IN FAMILY

NAME	ADDRESS	DATE OF BIRTH	SCHOOL ATTENDING	GRADE

Natural Parent ___Y ____N
Custodial Parent ____Y ____N
Guardian ____Y ____N

_____
Parent / Guardian Signature Date

OFFICE USE ONLY

Census Form Completed: ____Y ____N Records Requested _____ Rec'd _____
(date) (date)

Registered by:_____ Date_____ School _____ Grade _____ Transport _____

3/10

REGISTRAR

HICKSVILLE PUBLIC SCHOOLS
Screening Program Registration Form

Child's Name: _____ **DOB:** _____

Address: _____ **Telephone No.** _____

Parent/Guardian Name: _____

Entering Grade Level: _____ **Native Language spoke in the Home** _____

Number of Children in Family: _____ **Position in Family** _____

List Other Children in Family from One Day to 18 Years of Age

Name	Date of Birth	School Attending

Is child presently taking any medication? _____ **Please list medication:** _____

1. **Has your child ever been hospitalized?** _____ **Date:** _____
   If so, reason:
   _____
   Any other serious illness or injury?
   _____
2. **Please list any allergies:**
   _____
3. **Please list any speech problems:**
   _____
4. **Please list any special problems:**
   _____
5. **Has your child been screened or evaluated for Special Education?**
   _____
   If "yes", what school district?
   _____
6. **Has your child ever received Special Education services in another district?** _____
   If "yes", from : _____ **to** _____ **What school district?** _____
7. **Nature of services:** _____ **Resource Room Program**
   _____ **Special Class**
   _____ **Speech and Language Services**
   _____ **Other; please specify:**

Additional Comments: _____
_____
_____

I understand that all reports and testing results will be treated confidentially.

Parent/Guardian Signature: _____ **Date:** _____

HICKSVILLE PUBLIC SCHOOLS
Health Services

Dear Parent/Guardian:

Please complete this health history form and return it with your signature.

Student's Name: _____ Sex: _____

DOB: _____ Place of Birth: _____

Address: _____ Phone Number: _____

Mother: _____ Father _____ Guardian: _____

Family Physician: _____

Address: _____ Phone Number: _____

IF PARENT/GUARDIAN NOT AVAILABLE IN CASE OF EMERGENCY CALL:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

HEALTH HISTORY

Please explain any significant illness, operation or injuries:

_____

_____

_____

Does your child have any of the following: (Please explain any yes answer(s) below)

1.	**Asthma**	**Yes___ No___**	**7.**	**Chronic Illness**	**Yes___ No___**
2.	**Allergies**	**Yes___ No___**	**8.**	**Ear/Hearing Problem**	**Yes___ No___**
3.	**Diabetes**	**Yes___ No___**	**9.**	**Eye/Vision Problem**	**Yes___ No___**
4.	**Heart Condition**	**Yes___ No___**	**10.**	**Eyeglasses/Contacts**	**Yes___ No___**
5.	**Seizures/Epilepsy**	**Yes___ No___**	**11.**	**Takes Medication Daily**	**Yes___ No___**
6.	**Orthopedic Condition**	**Yes___ No___**	**12.**	**Skin/Rash Condition**	**Yes___ No___**

Explanation of "Yes" answers:

_____

_____

_____

Any items in bold (numbered items 1-7) that have a "Yes" answer, please fill out the back of this form.

Date: _____ Parent/Guardian Signature: _____

This form must be completed if you answered "Yes" to any item 1-7 on reverse side. Please note: a signed physician's prescription must accompany this form for any special medical considerations.

Physician(s) Clinic treating student: _____

Address: _____ Telephone No.: _____

Diagnosis: _____ Date of Onset: _____

Number of hospitalizations, reasons, outcomes, dates: _____

What were the signs and symptoms of the condition: _____

_____

_____

What specific treatments, interventions, approaches are used:

_____

_____

Does your child require use of any emergency medication (i.e. Epi-Pen, Benadryl, Glucagon, Valium, etc):

_____

_____

What are the special care needs in school (diet, treatments, equipment, prosthesis, braces, supplies, etc.):

_____

_____

What specific medications will your child need to take during school hours and when:

_____

_____

_____

_____

What special consideration do you have related to your child's condition while at school (i.e. educational, behavioral, physical education precautions, sports precautions, recess precautions, field trips):

_____

_____

How does the condition affect the degree of physical activity the student can do:

_____

_____

If your child has a problem at school related to his/her condition, what plan of action would you and your physician prefer the school personnel to take:

_____

_____

Please indicate if you have any concerns about having the above information shared with the Classroom teacher(s), bus driver and other appropriate school personnel: Yes*____ No ____
(*school nurse will contact you to discuss your concerns).

Parent/Guardian Signature: _____

*****PLEASE NOTE****

Medical forms must have an original doctor's signature as well as the doctor's office stamp. If your Doctor wants to use his form, it must have an original signature and the Doctor's office stamp on it.

LIST OF COMMUNITY RESOURCES FOR MEDICAL CARE:

1. Westbury/New Cassel Community Health Center
   682 Union Ave.
   Westbury, NY
   571-9500

2. Dr. Karl Freidman, M.D.
   Split Rock Medical Building
   66 Split Rock Road
   Syosset, NY 11791
   921-3131

3. Doctors Immediate Care
   1610 Old Country Road
   Westbury, NY
   228-4900

4. Pediatric Ambulatory Care Center
   Nassau University Medical Center
   Hempstead Tpke.
   East Meadow, NY 11554
   572-6367

HICKSVILLE PUBLIC SCHOOLS

Certificate of Immunizations

This is to certify that _____ _____
(First Name) (Last Name)

Grade_____ School_____ Date of birth_____

Received the following immunizations (give full date: month, day, and year)

Measles_____ _____ (Disease Date:_____) (Titer Done:_____)

Mumps_____ _____ (Disease Date:_____) (Titer Done:_____)

Rubella_____ _____ (Disease Date:_____) (Titer Done:_____)

MMR_____ _____

Hib:_____ _____

Polio: (IPV, OPV)_____ _____ _____ _____ _____ _____

DPT/D Tap:_____ _____ _____ _____ _____ _____

DT/TD:_____ _____ _____ _____ _____ _____

Tdap:_____ _____ _____

Meningococcal:_____ _____ _____ _____

Hep B:_____ _____ _____ _____

Varicella:_____ _____ (Disease Date:_____)

Lead Screening:_____ _____

PPD:_____ CXR:_____

( ) Religious or Medical Exemption ( ) Serological Report Attached

(Documentation attached)

Physician Stamp: **Date**_____ _____
Physician Signature

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HICKSVILLE SCHOOLS HEALTH APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ☐ M ☐ F **Grade:** _____

HEALTH HISTORY

(Parent Circle Yes or No)

1. Has your child ever had any fractures, dislocations, severe sprains or serious injuries?	Yes	No
2. Has your child ever been hospitalized or treated in an emergency room?	Yes	No
3. Has your child ever had surgery?	Yes	No
4. Has your child any allergies ___ Seasonal; ___ Life threatening; ___ Asthma; ___ Medication	Yes	No
5. Does your child take any medication now?	Yes	No
6. Has your child ever experienced any type of head injury or concussion?	Yes	No
7. Has your child had any chronic disease?	Yes	No
8. Does your child have a heart murmur, high blood pressure extra heartbeat or any heart abnormality?	Yes	No

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN BELOW:

_____

To the best of my knowledge, the above information is correct:

Parent/Guardian Signature_____ Date: _____

PHYSICAL EXAM TO BE COMPLETED BY PHYSICIAN

☐ Immunization record attached Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____

☐ No immunizations given today Dental Referral ☐ Yes ☐ No ☐ Not done Date: _____

☐ Immunizations given since last Health Appraisal:

_____

Significant Medical/Surgical History: ☐ See attached _____

_____

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension

☐ Other: _____

Allergies: ☐ **LIFE THREATENING** ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____

☐ Seasonal ☐ Medication: _____

Height:	Blood Pressure: Pulse:
Weight:	Abdomen:
Eyes:	Hernia:
Ears:	Heart:
Vision:	Lungs:
Nose & Throat:	Orthopedic:
Mouth & Teeth:	Scoliosis:
Skin:	Other:

Student requires medication? Yes ___ No ___. If yes, please specify:

Student may carry inhaler and self-administer: Yes ___ No ___ I assess this student to be self-directed: Yes ___ No ___

				Referral
Body Mass Index: _____ _____ . _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th	Vision - Near Point	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities**

Provider's Stamp below:

Provider's Signature: _____

Actual Date of Examination: _____

(OVER ——→)

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 10/3/07*

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

IMMUNIZATION RECORD TO BE COMPLETED BY PHYSICIAN

Immunizations	Date 1st dose	Date 2nd dose	Date 3rd dose	Date 1st booster	Date 2nd booster	Date 3rd booster
Polio						
DPT						
TD or DT						
Tdap						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis B						
Varicella						
Pneumococcal						
Meningococcal						
PPD (Tuberculin)						
Hepatitis A						
Lead						
Other						

Legal requirement for immunization waived because of: Religious exemption _____ Medical exemption _____

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

DISPOSITION: **Full Unlimited Participation _____ in all sports listed below:**

May the student participate in the following interscholastic sports?

Contact Sports: **Yes ____ No ____**

(Football, Lacrosse (boys), Wrestling)

Limited Contact Sports: **Yes ____ No ____**

(Basketball, Baseball, Gymnastics, Lacrosse (girls), Soccer, Softball, Cheerleading, Kickline)

Non-Contact Sports: **Yes ____ No ____**

(Cross Country, Swimming, Tennis, Track & Field, Weight Training, Volleyball)

Moderately Strenuous Sports: **Yes ____ No ____**

(Bowling, Golf)

☐ **Specify medical accommodations needed for school:** _____ ☐ None

☐ **Known or suspected disability:** _____ ☐ Please monitor

☐ **Restrictions:** _____ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other:

Rev. 3/08

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 10/3/07*

Hicksville Public Schools
Prior Special Education Programs/Services

Student's Name _____ DOB: _____

Street Address _____ Phone: _____

School Attended _____ District: _____

Address _____ Phone #: _____

Last Grade Completed _____ Teacher/Counselor's Name: _____

Did student receive any special education services? □ No □ Yes (indicate below):

If you responded "YES" to the above, please complete:

Type of Special Education Program Attended:

□ Resource Room □ Special Class □ Consultant Teacher □ Related Services
□ BOCES Special Education: School Name _____
□ Other (Specify type of program or name of school _____

Related Services Provided in Most Recent Placement: check all that apply

□ Speech/Language □ Counseling □ Occupational Therapy
□ Physical Therapy □ Hearing Services □ Vision Services

Classification (if known)

□ Learning Disabled □ Mentally Retarded □ Speech Impaired
□ Emotionally Disturbed □ Other Health Impaired □ Multiply Disabled □ Autistic
□ Deaf □ Orthopedically Impaired □ Hard of Hearing □ Deaf-Blind
□ Visually Impaired □ Traumatic Brain Injury

Do you have a copy of your child's most recent IEP: □ No □ Yes (please attach)

Name of CSE Chairperson/Special Education Director _____

Address of CSE Office _____ Phone # _____

Release of Records/Information to the Hicksville Public Schools

I authorize the school and CSE indicated above to release academic, psychological, psychiatric, medical and all other evaluations, IEPs, and records to the Hicksville schools. I am aware that all records will be kept confidential and access limited to school personnel who work with my child. I understand I may review all records. I also consent to having school district personnel who work with my child principal, psychologist, social worker, regular or special education teachers, related service providers, guidance counselor and/or CSE Chairperson) speak with individuals from the school and CSE office indicated above. I am aware my consent is voluntary and can be withdrawn at any time.

_____ _____
Signature of Parent/Person in Parental Relationship Date

FOR OFFICE USE ONLY: Please forward copies of all evaluations and records to:

Committee on Special Education
Hicksville School District
200 Division Avenue
Hicksville, NY 11801
(516) 733-2160 Fax: (516) 733-6683

HICKSVILLE PUBLIC SCHOOLS
STUDENT RACIAL AND ETHNIC IDENTIFICATION

All students between 5 and 21 years of age have the right to a free and public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition or immigration status.

Name of School:	
Student Name: Last, First, Middle:	Grade Level:
School District Student Identification Number:	Date of Birth (Month/Day/Year): / /

DIRECTIONS TO PARENT/GUARDIAN
PLEASE ANSWER ALL QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check (✓) the box that best describes your child.] Check (✓) only ONE box.

1. **Is the student Hispanic, Latino, or of Spanish Origin?** Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.
   - ☐ **Yes, Hispanic**
   - ☐ **No, not Hispanic**

2. ***Select one or more races from the following five racial groups*** [For question (2) Check (✓) all groups that apply to your child; check (✓) at least ONE box]:
   - ☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
   - ☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
   - ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
   - ☐ **BLACK OR AFRICAN AMERICAN:** A person having origins in any of the Black racial groups of Africa.
   - ☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Signature of Parent/Guardian/Other _____ Date _____

Relationship to Student (please check one box below)

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify):_____

See reverse for important message to Parents/Guardians and confidentiality Procedures and Regulations.

HICKSVIILE PUBLIC SCHOOLS
STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/Guardian: Hicksville Public Schools has adopted a policy which requires the collection and recording of the ethnic identity of students in Hicksville Public Schools in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task.. Please review the Racial/Ethnic definitions on the back of this page. Put a (✓) in the box for the category or categories which best describe your child. Hicksville Public Schools understand the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all Sate and federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records office from the school or district will be required to identify the group which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: this form will be filed in the student's permanent record as confidential information

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable be either student name or student identification number

Please complete the form on the reverse side of this page

HICKSVILLE PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL EDUCATION AND PUPIL PERSONNEL SERVICES
REGISTRTION OFFICE

200 Division Avenue
Hicksville, New York 11801
Telephone (516) 733-2168 Fax (516) 733-6683

PARENTAL REQUEST FOR TRANSFER OF RECORDS FORM

PARENT/GUARDIAN PRINT LEGIBLY AND PROVIDE SIGNATURE TO AUTHORIZE RELEASE OF SCHOOL RECORDS:

DATE OF REQUEST: _____ **DATE FIRST ENTERED HICKSVILLE:** _____

STUDENT: _____ **DOB:** _____ **GRADE:** _____

FORMER SCHOOL: _____

FORMER SCHOOL PHONE NUMBER: _____ **FAX NUMBER:** _____

FORMER HOME ADDRESS: _____

PARENTAL NAME AND SIGNATURE: _____

FORMER DISTRICT PLEASE SEND ALL PERTINENT EDUCATIONAL RECORDS TO:

__ Burns Avenue School, 40 Burns Avenue, Hicksville, NY 11801; Phone (516) 733-2311 Fax 733-6694

__ Dutch Lane School, 50 Stewart Avenue, NY 11801; Phone (516) 733-2361 Fax 733-3520

__ East Street School, 50 East Street, Hicksville, NY 11801; Phone (516) 733-2321 Fax 733-3533

__ Fork Lane School, 4 Fork Lane, Hicksville, NY 11801; Phone (516) 733-2341 Fax 733-3521

__ Lee Avenue School, 1 Seventh Street, Hicksville, NY 11801; Phone (516) 733-2351 Fax 733-3522

__ Old Country Road School, 49 Rhodes Lane, Hicksville, NY 11801; Phone (516) 733-2301 Fax 733-3523

__ Woodland School, 85 Ketcham Road, Hicksville, NY 11801; Phone (516) 733-2331 Fax 733-3524

__ Middle School, 215 Jerusalem Avenue, Hicksville, NY 11801; Phone (516) 733-2272 Fax 733-6528
ATTENTION GUIDANCE DEPARTMENT

__ High School, 180 Division Avenue, Hicksville, NY 11801; Phone (516) 733-2221 Fax 733-1194
ATTENTION GUIDANCE DEPARTMENT

PLEASE SEND ALL SPECIAL EDUCATION IEP'S or 504 PLAN AS APPLICABLE TO BE SENT TO:

__ Committee on Special Education, Hicksville Public Schools, 200 Division Avenue, Hicksville, NY 11801, Phone (516) 733-2160; Fax (516) 733-6683